SOUTH DAKOTA BOARD OF NURSING
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115
(605) 362-2760 ♦ Fax: 362-2768 ♦ doh.sd.gov/boards/nursing

GENERAL INSTRUCTIONS FOR RN + APN LICENSURE RENEWAL

Please follow instructions carefully to avoid delays in processing your renewal. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees your application will be considered for renewal. You will be notified in writing if additional information is required.

❑ Renewal or Inactivation: RN and APN License(s)

(See Compact Registered Nurse license information below.)

1. Complete and sign Advanced Practice Licensure Request Form. Send that completed form, the completed Nurse Survey Questionnaire, and appropriate fees (identified below) to the South Dakota Board of Nursing.
2. All forms and fees must be postmarked by your expiration date or your license will lapse. **You cannot work on a lapsed license**, and are responsible to maintain licensure whether or not you receive a renewal notice.

❑ Fees

1. Fee payment should be in the form of a money order or a cashier's check to South Dakota Board of Nursing. Fees are non-refundable and must accompany renewal form.
2. To renew both your South Dakota RN license **and** Advanced Practice Nursing license:
   - $90 **RN** renewal fee + $70 **CNM** renewal fee = $160
   - $90 **RN** renewal fee + $70 **CNP** renewal fee = $160
   - $90 **RN** renewal fee + $70 **CRNA** renewal fee = $160
   - $90 **RN** renewal fee + $70 **CNS** renewal fee = $160
3. To renew your South Dakota Advanced Practice license **only** (see RN Compact information below):
   - $70 **CNM** renewal fee
   - $70 **CNP** renewal fee
   - $70 **CRNA** renewal fee
   - $70 **CNS** renewal fee

❑ Registered Nurse License

1. You must have a current, valid, unencumbered South Dakota RN license or temporary permit to practice as APN in SD.
2. *Or* – Provide a copy of your current, valid, unencumbered compact RN license from your primary state of residence (where you hold a driver's license, pay taxes, and/or vote).
   - South Dakota is a member of the Nurse Licensure Compact. For more information on the Nurse Licensure Compact, see www.ncsbn.org.
   - Your compact RN license will be monitored by SD Board of Nursing through a national verification system.
   - **If you fail to maintain current RN licensure in your primary state of residence, you do not meet licensure requirements and must cease practice as an APN in South Dakota.**

❑ Verification of Employment

1. Verification of worked hours as a RN is required for South Dakota RN license renewal.
2. Complete Verification of Employment or Volunteer Work as a Registered Nurse Form and provide worked or volunteered hours in a position requiring nursing knowledge and skills for at least 140 hours in any 12 month period within the last six years **or** 480 hours within the last six years.

❑ Certification Verification

Primary source verification of *current certification* from a Board-approved certification organization specific to your area of practice is *required to be on file* with the Board office prior to your APN license being renewed. Board-approved certification organizations include: American Academy of Nurse Practitioners (AANP), American Midwifery Certification Board (AMCB), American Nurses Credentialing Center (ANCC), National Certification Corporation for OB, GYN, & Neonatal Nursing Specialties (NCC), Pediatric Nursing Certification Board (PNCB), and Council on Certification of Nurse Anesthetists (CCNA).

If you are unsure if you have current certification on file, contact the Board office. If you do not have primary source verification of your certification on file:

1. Complete the top section of the Certification Verification Form, then forward the form to your certifying organization with the appropriate fee.
2. The certifying organization will return the completed form directly (primary source) to the Board of Nursing.
3. Please note:
   - **CRNAs**: Primary source verification of your re-certification status will be monitored by the BON on CCNA's online verification website. You must provide your AANA/CCNA certification number on the renewal form. You do *not* need to complete and send the above referenced form to the CCNA.
   - **CNPs** or **CNSs** certified with NCC or ANCC must submit online requests to NCC and ANCC for primary source verification to be sent to the Board of Nursing. These organizations may require an additional fee.
   - **Certification Waiver:**
     - You are exempt from the **CNP/CNM** certification requirement if you were originally licensed as a CNP/CNM in South Dakota before June 26, 1996 and have never submitted certification evidence to the South Board of Nursing for licensure purposes.
     - You are exempt from the **CNS** certification requirement if you were originally licensed as a CNS in South Dakota before July 1, 1996 and have never submitted certification evidence to the South Dakota Board of Nursing for licensure purposes.

❑ Collaborative Agreement Information (Applicable to CNP and CNM only)

To perform the overlapping scope of advanced practice nursing and medical functions with a physician licensed in South Dakota as defined in SDCL 36-9A-12 and SDCL 36-9A-13, CNMs and CNPs must have on file a current Joint Board of Nursing and Medical and Osteopathic Examiners approved collaborative agreement (SDCL 36-9A-15 and SDCL 36-9A-17).

Collaborative Agreement renewal is not required with licensure renewal, as long as the terms defined in the agreement describe current practice. The CNP/CNM is accountable to maintain current status of all collaborative agreements on file with the Boards. Once a collaborative agreement has been reviewed and approved by the Boards, it remains in effect until a new collaborative agreement has been submitted and approved. To obtain a collaborative agreement, go to the Board of Nursing website and select Advanced Practice and your specialty.

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ADVANCED PRACTICE NURSE LICENSURE REQUEST FORM

I request to ***renew*** each license checked:

- ❑ ***Registered Nurse** - $90 fee
- ❑ **Certified Nurse Midwife -** $70 fee
- ❑ **Certified Nurse Practitioner -** $70 fee
- ❑ **Certified Registered Nurse Anesthetist -** $70
- ❑ **Clinical Nurse Specialist -** $70 fee

Complete below portion of this form and return with fee.

***To practice as an APN in SD, you must hold both a RN license and an APN license.**
SD is a compact RN state; for more information on compact states, see www.ncsbn.org.

I do not wish to renew my license(s) and request to ***inactivate*** each license checked.

- ❑ **Registered Nurse** - $10 fee
- ❑ **Certified Nurse Midwife** - $10 fee
- ❑ **Certified Nurse Practitioner** - $10 fee
- ❑ **Certified Registered Nurse Anesthetist** - $10 fee
- ❑ **Clinical Nurse Specialist** - $10 fee

Sign, date and return this form with fee.

Signature _____

Date _____

Demographic Data

Please Print

Name: First_____ Middle_____ Last _____

Other names previously used:_____

Address:_____
Street/PO Box City State Zip

Telephone: Home: (___)_____ Other: (___)_____ Email: _____

Date of Birth:_____ Gender: ❑Male ❑Female Social Security #: _____

Race/ Ethnicity: ❑White ☐ Black ❑Hispanic ❑Asian or Pacific Islander
❑American Indian or Alaskan Native ❑Other

Declaration of Primary State of Residence

❑ I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is:

_____. This is my "home state" under the Nurse Licensure Compact and is my "declared fixed permanent and principal home for legal purposes."

– OR –

❑ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer:_____

RN License # in primary state of residence if other than South Dakota:_____

Certification Information

- ❑ I am a **CRNA:** AANA/CCNA # _____. Primary source verification of your re-certification status will be monitored on CCNA's verification website.
- ❑ Primary source verification of my current certification is **already on file** with BON. (You do not need to resubmit.)
- ❑ I have requested primary source verification from my certification organization be sent to SD BON verifying my on-going currency of certification. See Certification Verification Form. Copies of certification documents are not accepted.
- ❑ I am **exempt** from certification requirement. I was originally licensed as a **CNP/CNM** in South Dakota before June 26, 1996 or as a **CNS** before July 1, 1996 and have never submitted certification evidence to BON for licensure purposes.

	Disciplinary Information		
1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Within the last two years, have you been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒NO
8.	Within the last two years, have you experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO
For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.			

Collaborative Agreement Information (Applicable to CNM and CNP only)

- ❑ I do not have a collaborative agreement on file with the Boards. I do not perform the overlapping scope of advanced practice nursing and medical functions as defined in 36-9A-12 / 36-9A-13.
- ❑ I have included a new or revised collaborative agreement with this application to be approved by the Boards.
- ❑ I have a collaborative agreement(s) on file with the Boards. My **primary physician** for **each agreement** is listed below:

Primary Physician: _____

Primary Physician: _____

Primary Physician: _____

Primary Physician: _____
(List others on back)

AFFIDAVIT

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant _____ **Date** _____

(7/02, 11/02, 7/03, 7/04, 9/06)

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VERIFICATION OF EMPLOYMENT

To obtain/retain active status license, the applicant must provide verification of employment in nursing within the previous six years of at least 140 hours in any 12-month period OR an accumulated 480 hours. If you have not worked or volunteered the required number of hours in nursing and wish to obtain a license, contact the SD Board of Nursing for more information.

APPLICANT: COMPLETE THIS SECTION AND FORWARD THE FORM TO YOUR EMPLOYER(S)/FORMER EMPLOYER(S).
THIS FORM MAY BE DUPLICATED FOR ADDITIONAL VERIFICATIONS.
RETURN THE COMPLETED FORM(S) TO THE SOUTH DAKOTA BOARD OF NURSING.

NAME: _____
First Middle Maiden Last Other(s):

ADDRESS: _____
Street or PO Box City State Zip

SS#

❒ I have been employed/volunteered as a ❒RN / ❒LPN within the last six years.

❒ I have not been employed as a nurse within the past six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

_____
SIGNATURE OF APPLICANT DATE

THIS SECTION TO BE COMPLETED BY EMPLOYER

The above-named individual (was) employed/volunteered as a nurse	From:	To:
	Total hours worked in this period:	

I, the undersigned, declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

SIGNATURE OF AGENCY REPRESENTATIVE/TITLE DATE

NAME OF EMPLOYER:

ADDRESS OF EMPLOYER:

TELEPHONE: EMAIL:

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CERTIFICATION VERIFICATION FORM

Complete items 1 – 8 on this form then forward to certification organization.

Please Print

1. Name: First_____ Middle_____ Last _____
2. Other names previously used:_____
3. Address:_____
   Street/PO Box City State Zip
4. Name of Certification Organization_____
5. Certification #_____ Expiration Date_____
6. Certification status (check one): ❑ Initial certification verification ❑ Recertification verification
7. Certification type (check one): ❑ CRNA ❑ CNS ❑ CNM ❑ CNP
8. Consent to *Release Information* to the South Dakota Board of Nursing:

   I authorize the above named certification organization to disclose information regarding the identification, evaluation, and certification of the above named applicant that is maintained by the above named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

_____ _____
Applicant Signature Date

Certification Organization: complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____	
Certification #	Date of Current Certification Maintenance Cycle/Recertified through:
Certification type: ❑ CNM ❑ CNS – specialty area_____ ❑ CRNA ❑ CNP – specialty area_____	
Is certification current? ❑YES ❑NO (Please explain on a separate paper)	Has certification lapsed? ❑YES (Please explain on a separate paper) ❑NO
Has certification been revoked? ❑YES (Please explain on a separate paper) ❑NO	Is certification provisional/conditional in any manner? ❑YES (Please explain on a separate paper) ❑NO
_____/_____ Name/Signature of person completing form Title	_____ Date

NURSE SURVEY QUESTIONNAIRE

Please circle ONE number in each category below that best represents your current practice.

Survey Date: _____

EMPLOYMENT STATUS	
1	Full-Time Nurse
2	Part-Time Nurse
3	Full-Time other than Nursing
4	Part-Time other than Nursing
5	Volunteer Nurse
6	Unemployed
7	Retired Nurse

WHERE PRESENTLY EMPLOYED	
County:	
State:	
City:	
Zip Code:	

TYPE OF POSITION	
1	Nurse Management
2	Consultant
3	Case Manager
4	Nursing Program Faculty
5	Clinic Nurse
6	Staff Nurse
7	Advanced Practice Nurse (CRNA, CNP, CNM, CNS)
8	Charge Nurse
9	Inservice Educator/Staff Development
10	Other:

ADVANCED PRACTICE NURSES ONLY	
1	Certified Registered Nurse Anesthetist (CRNA)
2	Certified Nurse Practitioner (CNP)
3	Certified Nurse Midwife (CNM)
4	Clinical Nurse Specialist (CNS)

FORMAL EDUCATION ACTIVITIES	
1	I am not taking courses toward an advanced degree in nursing
2	I am currently taking courses toward an advanced degree in nursing

PRINCIPAL FIELD / PLACE OF EMPLOYMENT	
1	Hospital
2	Nursing Home / Long Term Care
3	Nursing Education Program
4	Home Health / Hospice
5	School
6	Outpatient Surgical Center
7	Office / Clinic
8	Community Health
9	Self-Employed
10	Other:

HIGHEST DEGREE HELD	
1	Diploma / Registered Nurse
2	Associate Degree / Registered Nurse
3	Baccalaureate Degree / Registered Nurse
4	Baccalaureate in other field
5	Masters in Nursing
6	Masters in other field
7	Doctorate (PhD, Ed, DNSc)
8	Diploma / Associate Degree / Practical Nurse

WHAT PERCENT OF YOUR CURRENT POSITION INVOLVES DIRECT PATIENT CARE?									
1	0%	2	25%	3	50%	4	75%	5	100%

DO YOU INTEND TO LEAVE/RETIRE FROM NURSING PRACTICE IN THE NEXT 5 YEARS?	1	Yes	2	No

STATES OTHER THAN SD IN WHICH YOU ARE LICENSED AS A NURSE: _____

_____